MARY MARSHALL NURSING SCHOLARSHIP PROGRAM FOR LICENSED PRACTICAL NURSES
2011 APPLICATION

APPLICATION REQUIREMENTS

Please ensure that you read and understand the following information prior to applying for a scholarship award. **Failure to comply with any of these application requirements will result in the applicant being ineligible for a scholarship.**

1. All items on the application form **must be answered**.

2. Applicants must be a high school graduate or have a GED. (Proof must be submitted along with application).

3. Applicants must be enrolled as a full-time or part-time nursing student and engage in nursing study at the time of the award. Applicants enrolled as part-time students must report the total number of hours they are taking.

4. Applications and transcripts must be postmarked by **June 30** for the academic year beginning in the fall of the calendar year you are applying. (Applications are not accepted prior to May 1.)

5. Both the Dean/Director/Chair of the School of Nursing and the Financial Aid Officer/Authorized person must provide original signatures in their sections of the application.

6. **Applications must be typed; handwritten applications will not be accepted.**

7. It is the responsibility of the applicant to see that:

    a. The application form is completed entirely;

    b. All original signatures are obtained on the application forms; and

    c. Application and official grade transcript are to be postmarked prior to **June 30** to:

    Virginia Department of Health
    Office of Minority Health and Health Equity
    ATTN: Mary Marshall Nursing Scholarship
    109 Governor St., Suite 1016-East
    Richmond, Virginia 23219

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CHECKLIST

This checklist has been provided to facilitate your application process. Please ensure that all items have been completed or submitted with the application prior to mailing. The applicant is responsible for ensuring that the application is complete. Only completed applications will be considered for scholarship awards.

Please keep this checklist for your records.

☐ A completed Mary Marshall Nursing Scholarship Program Licensed Practical Nurse Application for 2011-2012, with original signatures. **Old applications and handwritten applications will not be accepted.**

Please be sure that:

☐ All items on the application are addressed.

☐ Program Director or authorized school official has completed their section(s) of the application. (Sections 8, 9, and 10)

☐ All authorized school officials have signed and dated the application in the designated places.

☐ You have requested a high school transcript or have provided a copy of your GED with the application.

☐ The application is to be postmarked to the Office of Minority Health and Health Equity by the June 30 deadline.

☐ **You maintain a copy of this application for your records.**

SECTION 1 – PERSONAL DATA

Date of Application: _____

Legal Name: _____
Last First MI Maiden

_____
Preferred Name

Address: _____
Street Number and Name

_____
City State Zip

Day Phone Number: (000) 000-0000 Evening Phone Number: (000) 000-0000

Email Address: _____

Social Security Number: 000-00-0000 Sex: Please Select One

Date of Birth: _____ Place of Birth: _____

Race/Ethnicity: Please Select One Other: _____

How long have you been a resident of Virginia? _____

Congressional District: (Please check with your voter registration office or visit http://nationalatlas.gov/printable/congress.html)

Are you a high school graduate? Please Select One Do you possess a GED? Please Select One

Are you a certified nursing assistant (CNA)? Please Select One

Have you ever received a Mary Marshall Nursing Scholarship? Please Select One

If yes, in what year(s)? _____

If you had a different name when you applied previously, please provide it here: _____

What school of nursing were you attending during that time? _____

Do you speak another language? Please Select One If yes, please list: _____

CONTACT PERSON (OTHER THAN APPLICANT)

Name: _____ _____
Last First MI

Address: _____
Street Number and Name

_____ _____
City State Zip

Phone Number: (000) 000-0000 Relationship to Applicant: _____

SECTION 2 – NURSING EDUCATION

School of Nursing: _____

Student Identification Number (if available) _____

Address: _____
Street Number and Name

_____
City State Zip

Phone Number : (000) 000-0000

☐Full-time Student: ☐Part-time Student: If Part-time student, how many credit hours are you taking? _____

Date of enrollment in present Nursing Program: Month Year

Expected date of graduation: Month Year

Have you transferred to this school from another nursing program? Please Select One

Name of previous school: _____

SECTION 3 – PRIOR EDUCATION

	School	Diploma/Degree	City and State	Date of Attendance	Reason for Leaving
1.				-	
2.				-	
3.				-	

SECTION 4 – WORK EXPERIENCE

Check here if you have never been employed, and skip to Section 5

	Type of Position	Name of Employer	City and State	Dates of Employment	Reason for Leaving
1.				-	
2.				-	
3.				-	

SECTION 5 – OTHER FINANCIAL ASSISTANCE

Are you receiving any other type of financial aid for the upcoming school year? Please Select One

Please indicate: _____

SECTION 6 – NARRATIVE SUMMARY (Required)

Explain briefly, *in one full page*, the significance of the Mary Marshall Nursing Scholarship in pursuing your educational goals. (Explain your financial need, and include your plans for professional practice following graduation)

Signature of Applicant

Date

SECTION 7 – CERTIFICATION STATEMENT

All of the information on this scholarship application is true and complete to the best of my knowledge. I realize that information from this application will be used to determine my scholarship eligibility. If asked by the Nursing Scholarship Advisory Committee, I agree to provide documentation verifying any information on this application. I have read and accept the conditions of the Mary Marshall Nursing Scholarship.

Signature of Applicant

Date

Full Name (Please Print)

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SECTION 8 – STATEMENT OF FINANCIAL NEED

To be completed by the Financial Aid Officer or Program Director

Please print this form after completion, please provide original signature and provide to scholarship applicant to be mailed with the rest of their application.

Full Name of Applicant: _____

Full Name of School of Nursing: _____

Student Identification or Social Security Number _____

This section must include a monetary recommendation.

This section must include a monetary recommendation. The Mary Marshall Nursing Scholarship is a need-based aid program; therefore, the amount recommended must be documented by one of the accepted uniform methodology needs analysis systems. Please use the most recent needs analysis on file for this student to recommend the amount of scholarship required to meet need, after taking into consideration other financial aid already received by the applicant.

Student Costs and Resources:

1. Student Aid Budget for Applicant _____
   Expected Family Contribution (EFC) _____
   Financial Aid Received (excluding loans) _____
   Remaining Need _____
   Cost of Program for One Year (including tuition, fees, books, uniforms, etc.) _____

2. Scholarship Recommendation:
   Based upon a review of this applicant's financial situation, I recommend a Mary Marshall Nursing Scholarship award of (*check one*):
   - ☐ $800 to $1,000
   - ☐ $500 to $800
   - ☐ $0 to $499

3. Please specify any extenuating circumstances which may have influenced your recommendation.

Name of Financial Aid Officer/Authorized Person (Please Print) _____ Phone Number _____

Signature of Financial Aid Officer/Authorized Person _____ Date _____

E-Mail Address _____

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SECTION 9 – STATEMENT OF SCHOLASTIC ATTAINMENT

To be completed by the Program Director

Please print this form after completion, provide original signature and then forward to the scholarship applicant to be mailed with the rest of their application.

Please describe the applicant's scholastic ability. It is important that students have the potential to complete their studies because of the financial penalty involved in paying back scholarship awards.

I certify that this student is a high school graduate or possesses a GED

Name of Program Director (Please Print)

Phone Number

Signature of Program Director

Date

E-Mail Address

SECTION 10 – SCHOOL OF NURSING RECOMMENDATION

To be completed entirely and signed by the Program Director

Must be filled in completely and signed by Program Director of School of Nursing.

1. Full Name of Applicant: _____
2. This applicant is: ☐ Attending ☐ Approved for admission
3. Date of Entrance: Month _____ Year _____
4. During this award period, the applicant will be a ☐ Full-time student ☐ Part-time student
5. Student Identification or Social Security Number: 000-00-0000
6. Please specify any extenuating circumstances that may have influenced your recommendation

I recommend _____ for a Mary Marshall Nursing Scholarship Award.
Please Print Applicant's Full Name

_____ _____
Name of Authorized Person Completing this Section Title

_____ _____
Signature Date

Full Name of School of Nursing: _____

Phone Number: _____

E-Mail Address: _____